MILLIMAN WHITE PAPER

The role of pharmacy benefits on ACA market premiums

Decomposing premium trends in the individual and small group markets

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Commissioned by Pfizer, Inc.

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This paper examines the role of prescription drug costs in premium increases in the Patient Protection and Affordable Care Act (ACA) individual and small group marketplaces. We analyzed the historical cost and utilization of pharmacy and medical services and found that:

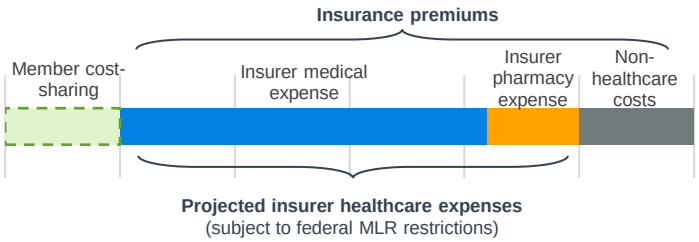
1. Actual pharmaceutical costs net of rebates, as a portion of premium, have remained relatively flat between 2014 and 2018, and
2. Projected net pharmaceutical costs, which are used in calculating premiums, have been underestimated from 2014 to 2016 and overestimated since 2017.

Premium setting and ACA rate filings

Our findings are based on the Unified Rate Review Template (URRT) filed annually with the Centers for Medicare and Medicaid Services (CMS) by insurers in the ACA-compliant market. The URRT reports an insurer's actual healthcare expenditures for its individual and small group business as well as cost projections used to develop premium rates. Pharmacy expenses are reported "net of rebates received from drug manufacturers" in the URRT.[1] Premiums are developed from actual healthcare cost experience using projection factors, including cost and utilization trends, disclosed in the URRT.

As shown in Figure 1, premiums are comprised of projected insurers' healthcare expenses, representing amounts to be reimbursed to providers for future medical and net pharmaceutical services, plus anticipated non-healthcare costs (e.g., insurer administrative expenses, profit margin, and taxes and fees). It is important to note that only payments made by insurers contribute to premium. Member cost-sharing, such as deductibles, copays, and coinsurance, are not an insurer's liability and therefore are excluded from the premium calculation, although they impact premiums by influencing member behavior.

FIGURE 1: ILLUSTRATION OF HEALTHCARE PREMIUM COMPONENTS



Note: Components are illustrative.

Pharmacy benefits contribution to costs and premiums

Using the URRT public use file (PUF) supplied by CMS, we determined the contribution of pharmacy benefits, net of pharmaceutical rebates, to healthcare premiums in recent years. In addition, based on URRT healthcare cost projections (which determine premiums), we decomposed premium trends by major categories of medical and pharmacy benefits.

The average net pharmacy contribution to premiums has grown slowly in both the ACA individual and small group markets since 2014. Most recently, insurers projected that net pharmaceutical benefits would consume about 17% and 15% of premiums in the ACA individual and small group markets, respectively. However, an analysis of historical experience in the individual and small group markets shows that the actual contribution of net pharmacy benefits to healthcare spend peaked in 2016 at 17% and 15%, respectively, and decreased to 14%, in both markets, in 2018. Figure 2 shows the average percentage of actual and projected net pharmacy spending contribution to premiums, by year and market.

On average, *actual* spending on net pharmacy benefits accounted for about 15% of premiums in the ACA individual market between 2014 and 2018. However, there was a wide

[1] Centers for Medicare and Medicaid Services. *2020 Unified Rate Review Instructions*. Retrieved August 6, 2020 from https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2020-URR-Instructions.pdf.

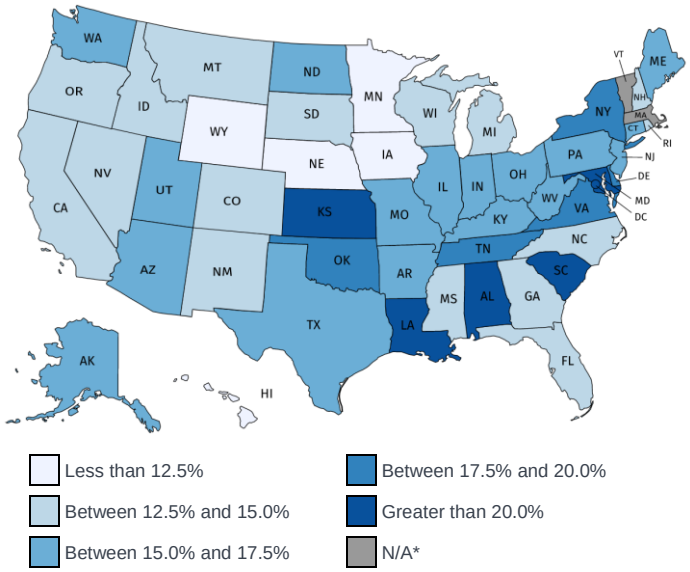
FIGURE 2: AVERAGE ACTUAL AND PROJECTED NET PHARMACY CONTRIBUTION TO PREMIUMS, BY YEAR AND MARKET

MARKET	2014	2015	2016	2017	2018	2019	2020
Actual							
Individual	14%	17%	17%	15%	14%	N/A	N/A
Small group	13%	14%	15%	15%	14%	N/A	N/A
Projected							
Individual	13%	13%	14%	17%	16%	17%	17%
Small group	14%	15%	15%	17%	16%	16%	15%
Difference (Actual – Projected)							
Individual	1%	4%	3%	-1%	-2%	N/A	N/A
Small group	-1%	-1%	0%	-2%	-2%	N/A	N/A

dispersion across states, with the average portion of premium consumed by net pharmacy benefits ranging from 11% for Hawaii, Minnesota, and Wyoming to 28% for South Carolina. Figure 3 illustrates this variation.

We observed similar variations by state in *projected* spending on net pharmacy benefits.[2] Several factors may influence state-by-state variation, including state regulations, prevalence of disease, and the relative risk pool of marketplaces.

FIGURE 3: AVERAGE ACTUAL NET PHARMACY CONTRIBUTION TO PREMIUMS BY STATE BETWEEN 2014 AND 2018, ACA INDIVIDUAL MARKET



* Massachusetts and Vermont have merged the individual and small group markets and thus does not have separate individual market information available.

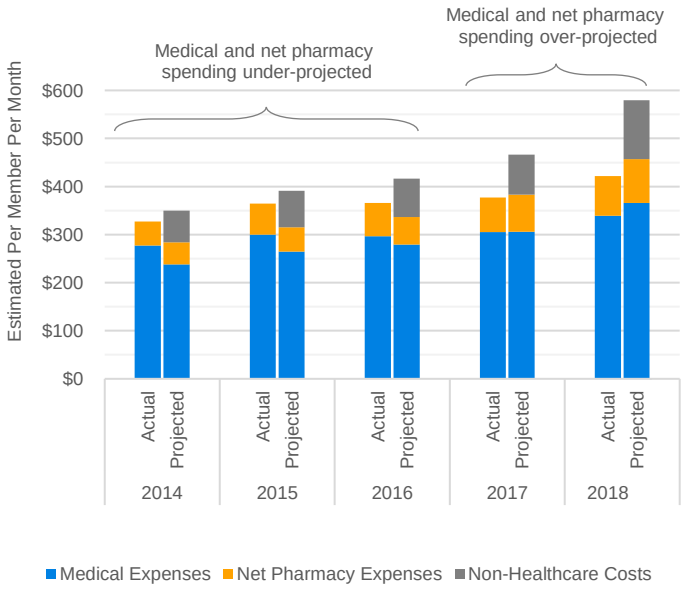
The role of pharmacy benefit trends on premium setting

Figure 4 illustrates the components of ACA individual market premiums using actual and projected data as reported in 2014 to 2020 URRTs.[3] In 2017 and 2018, actual medical and net pharmacy expenses paid by insurers were lower than what they had projected in premium development for the individual market. We found a similar dynamic in the small group market. This was in contrast to the three prior years (2014-2016) of the individual market, when actual medical and net pharmacy expenses were higher than projected.

Figure 5 illustrates the difference between projected trends (used to determine premiums) and actual trends for net pharmacy drug prices (the unit cost) for the periods 2014 to 2016 and 2015 to 2017. We report two-year trend periods, consistent with the rate-setting projection methods used in the ACA-compliant market.[4]

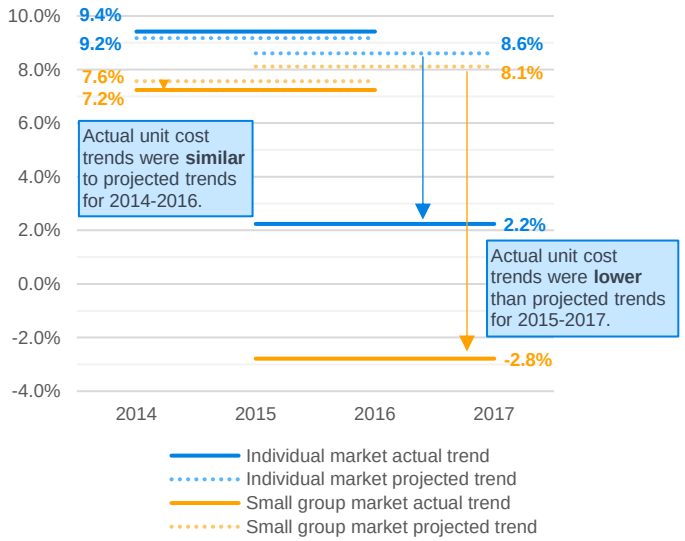
From 2014 to 2016, actual unit cost trends were approximately equal to or slightly lower than projected trends. However, from 2015 to 2017, actual unit cost trends fell to 2% and -3%, down

FIGURE 4: ANALYSIS OF ACTUAL AND PROJECTED HEALTHCARE EXPENSES PAID BY THE INSURER, ACA INDIVIDUAL MARKET



[2] Appendix 1 provides the detailed distribution of projected spending between service categories by state from 2018 to 2020.
[3] Actual non-healthcare costs (e.g., insurer administrative expenses, margins, taxes and fees, etc.) were not available through the URRT PUF, and therefore are not shown here.
[4] As of the 2020 URRT, which contains 2018 experience data, cost and utilization experience are no longer reported separately. Therefore, trend comparisons beyond 2017 could not be made.

FIGURE 5: ANALYSIS OF ACTUAL AND PROJECTED UNIT COST TRENDS FOR PHARMACY SERVICES BY MARKET



from 9% and 8%, for the individual and small group markets, respectively. Meanwhile, projected unit cost trends (used in the development of premiums) remained at the 2014 to 2016 levels, possibly due to insurers' reaction to the launch of new hepatitis C drugs in late 2013 and 2014.

Projected price (unit cost) trends for medical services (i.e., inpatient, outpatient, and professional) were also higher than actual trends in both the individual and small group markets, particularly between 2015 and 2017.

How trends in pharmacy benefits design impact premiums

Trends in benefits design also affect premium levels. Higher member cost-sharing such as deductibles, copays, and coinsurance reduce plan liability, which is associated with lower premiums.

We used the 2014-2018 Health Insurance Exchange (HIX) Compare data sets from the Robert Wood Johnson Foundation, which contain cost-sharing information for ACA-compliant plans in the individual and small group markets, to characterize pharmacy coinsurance. We also used experience membership information on a plan-level basis from the URRT PUF files provided by CMS to determine the prevalence and average level of cost-sharing features selected by members in ACA-compliant plans.

Coinsurance (a feature where patients pay a percentage of the cost of the services, as opposed to a flat dollar copay) is becoming a more common feature of pharmacy benefits in both the individual and small group markets. In 2018, three in four members were subject to coinsurance for specialty drugs, and over 50% of members had coinsurance on non-preferred brands, compared to only one-third for preferred brands. Copays continue to be popular for generic drugs, with just over 10% of members subject to coinsurance.

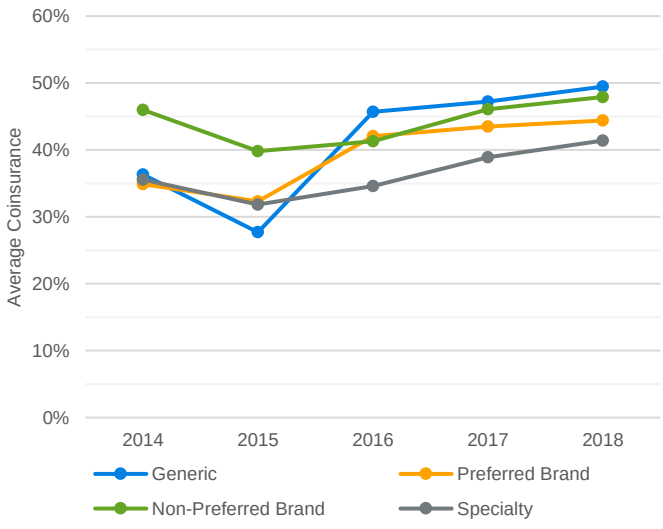
Figure 6 shows the average level of coinsurance in the individual market from 2014 to 2018 for pharmacy benefits, by drug tier. This figure reflects both benefit changes made by insurers and shifts in membership towards leaner plans. Since the coinsurance level for pharmacy benefits has increased in the individual and small group markets, members have been bearing a greater share of the cost of pharmaceutical drugs.[5]

A closer look at 2018 premium rates

We compared actual and projected healthcare expenses in 2018, the latest year available, to determine the impact of over- or under-projections on premium rates.[6] Figure 7 illustrates the impact of these differences on premiums in the ACA-compliant markets in 2018.

Inpatient, outpatient, professional, and pharmacy benefits all experienced lower-than-projected costs in 2018. The net pharmacy spending overstatement in the individual market was similar, in absolute dollars, to that for other medical healthcare

FIGURE 6: AVERAGE LEVEL OF COINSURANCE ON PHARMACY BENEFITS IN THE ACA INDIVIDUAL MARKET, 2014-2018



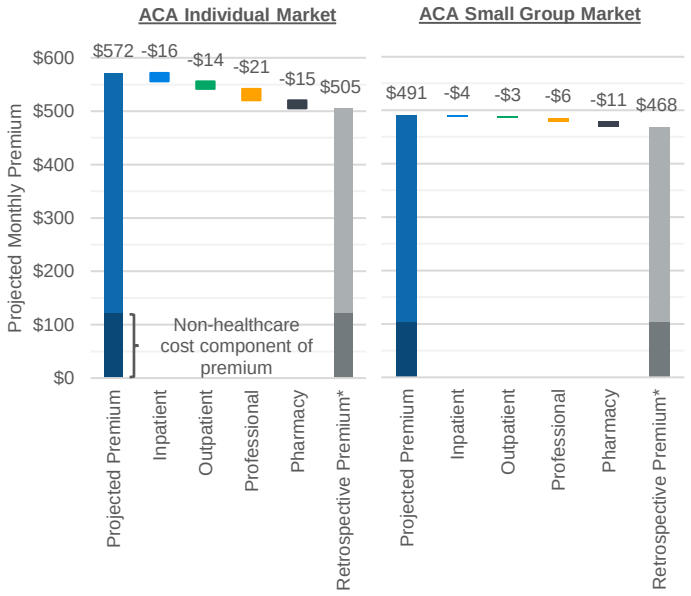
[5] Appendix 2 provides additional details on member cost-sharing for specialty drugs by state and market in 2018.
[6] At the time this report was written, 2018 was the latest year available for the reporting of actual expenses in URRT files.

services (between $14 and $21 per month by service). In total, over-projections of non-pharmaceutical medical expenses in the individual market contributed over $50 to projected premiums.

Overall, the premiums charged for 2018 in the ACA individual market were 13% higher than they would have been if based on actual spending (the "retrospective" premium shown in Figure 7), or $66 per month. In the small group market, however, premiums charged for 2018 were only 5% greater than retrospective premiums. The over-projections of net pharmaceutical expenses contributed to nearly 50% of the total over-projection of premiums in the small group market.

Under-projections of medical and net pharmacy expenses in the 2014-2016 period, as shown in Figure 4 above, have likely led to premium levels that were insufficient, on average. A lack of historical data for the new exchange markets, along with aggressive pricing in the early years of the market, may have contributed to under-projections of premiums. However, this under-projection was reversed in 2017, leading to an overstatement of premiums, as shown in Figure 7. Additional uncertainty in the ACA markets due to regulatory actions, including the defunding of CSR subsidies in 2018, the repeal of the individual mandate penalty, and the expansion of short-term medical policies, may have resulted in more conservative rate filings in recent years.

FIGURE 7: ESTIMATED IMPACT OF OVER-PROJECTIONS OF HEALTHCARE EXPENSES, 2018



Note: Darker shaded component of projected and retrospective premiums are estimates of non-healthcare costs based on URRT data.

* Retrospective premium is defined as the premium that would have been charged if projected claims costs were replaced with actual claims costs.

Discussion

Actual net pharmaceutical spend, as a percentage of premiums in the ACA marketplaces, has decreased slightly since 2016 in both the ACA individual and small group markets. We observed variation by state in the actual and projected net pharmaceutical contribution to premiums. On average, actual pharmacy spending, net of rebates, was roughly 15% of premiums in the ACA individual market between 2014 and 2018.

Our research into plan designs found that insurers have been shifting more of the cost of pharmaceutical drugs onto members using prescription drugs through both more frequent use of and higher levels of coinsurance on pharmaceutical benefits. Higher member coinsurance is one of the tools used by insurers to contain premium increases, as it reduces the insurer's exposure to high cost drugs and introduces incentives to manage patient utilization of services.

Our analysis of URRT PUF data found that in recent years actual net pharmaceutical expenses paid by insurers were lower than what they had assumed for premium development. Since 2017, net pharmaceutical spending *projected* by insurers has been greater than *actual* net pharmaceutical spending, reversing under-projections observed from 2014 to 2016. Due to this over-projection, 2018 premiums charged in the ACA individual and small group markets were 3% ($15) and 2% ($11) higher, respectively, than they would have been if based on actual net pharmaceutical spending. Over-projections in other service categories also contributed to higher premiums.

Methodology and data sources

We analyzed historical and projected data in URRT PUFs for carriers filing for individual or small group coverage in rating periods 2014 to 2020. Small group insurers have the option of refiling rates each quarter. We only considered the annual filing in our analyses.

Insurers include experience data in the URRT that is two years prior to the coverage year; that is, the URRT for the 2020 benefit year will typically contain 2018 experience. Thus, if an insurer did not file for rates in a particular year, its experience from two years prior was not available. We also excluded insurers that indicated their experience was not from the calendar year two years prior to the filing. Estimates of paid amounts by service were developed from average allowed amounts and actuarial values across all services, including medical and pharmacy benefits.

We also analyzed Health Insurance Exchange (HIX) Compare data sets published by the Robert Wood Johnson Foundation (RJWF) for plan years 2014 to 2018. The HIX Compare data sets

are public data files that include plan design information for all policies offered in the ACA-compliant health insurance marketplace.

In using the HIX Compare data sets, we obtained actual membership for plans from the URRT PUF. We excluded plan variants such as CSR plans or child-only plans, as the URRT PUF does not contain separate membership information for these variants. All membership in CSR plans is attributed to the base silver variant, which may result in variations from the actual level of member cost-sharing in the market.

Supporting data is included in appendices.

Caveats and limitations

The findings reported represent national averages in the individual and small group ACA-compliant marketplaces based on data reported by carriers in the URRTs. URRTs are only filed by carriers in the ACA-compliant marketplace, and historical data is not available for carriers that exit the market. Costs for other populations, or for any particular payer, may vary from those presented here.

Our study relies on experience by service categories as included in the URRTs. However, the level of detail in reported experience for specific service categories may vary by insurer. Note that insurers in the individual market adjusted premium rates in 2018 for the defunding of CSR subsidies. The way insurers reflected this adjustment in the URRTs may vary. Our study captures the average adjustment to the extent that it was reflected in the URRT.

This report was commissioned by Pfizer, Inc., a pharmaceutical drug manufacturer. The findings reflect the research of the authors. Milliman does not endorse any product or organization.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Dane Hansen, Nathaniel Jacobson, and Gabriela Dieguez are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report and rendering the actuarial opinions contained herein.

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Appendix 1: Distribution of Projected Premium Spending, 2018-2020

Note: Percentages in the table below indicate the estimated proportion of premium spending between 2018 and 2020 in inpatient facility services ("**IP**"), outpatient facility services ("**OP**"), professional services ("**Prof**"), other medical services including capitation ("**Oth**"), pharmaceutical drugs net of rebates ("**Rx**"), and spending on non-healthcare costs ("**NHC**"), including but not limited to administration expenses, taxes and fees, and profit/loss.

	ACA INDIVIDUAL MARKET							ACA SMALL GROUP MARKET						
ST.	**IP**	**OP**	**PROF.**	**OTH.**	**RX**	**NHC**	**TOTAL**	**IP**	**OP**	**PROF.**	**OTH.**	**RX**	**NHC**	**TOTAL**
AK	14%	22%	28%	2%	16%	18%	100%	15%	19%	33%	4%	11%	18%	100%
AL	17%	14%	19%	6%	22%	22%	100%	17%	16%	23%	9%	24%	12%	100%
AR	18%	20%	23%	5%	19%	14%	100%	15%	19%	23%	3%	18%	22%	100%
AZ	17%	15%	25%	4%	18%	21%	100%	17%	20%	23%	3%	12%	24%	100%
CA	25%	12%	24%	10%	14%	15%	100%	23%	13%	23%	12%	13%	17%	100%
CO	18%	22%	24%	3%	13%	20%	100%	18%	24%	23%	2%	11%	22%	100%
CT	16%	22%	20%	3%	16%	23%	100%	16%	20%	25%	3%	15%	21%	100%
DC	17%	17%	32%	4%	22%	8%	100%	14%	16%	25%	4%	19%	22%	100%
DE	21%	25%	20%	2%	17%	15%	100%	16%	21%	24%	3%	16%	19%	100%
FL	19%	21%	16%	7%	16%	21%	100%	16%	22%	18%	6%	15%	23%	100%
GA	17%	21%	23%	2%	18%	19%	100%	15%	23%	22%	3%	17%	20%	100%
HI	18%	16%	24%	8%	11%	21%	100%	17%	17%	30%	7%	14%	15%	100%
IA	15%	24%	20%	4%	14%	24%	100%	13%	22%	26%	4%	15%	20%	100%
ID	18%	25%	18%	11%	14%	14%	100%	16%	24%	20%	5%	14%	21%	100%
IL	15%	24%	15%	12%	16%	18%	100%	14%	25%	21%	7%	15%	17%	100%
IN	15%	21%	17%	1%	21%	25%	100%	17%	30%	16%	2%	14%	22%	100%
KS	18%	21%	19%	5%	18%	19%	100%	16%	23%	20%	4%	17%	19%	100%
KY	15%	23%	17%	1%	19%	26%	100%	14%	25%	18%	2%	20%	21%	100%
LA	16%	21%	22%	3%	20%	18%	100%	14%	21%	25%	2%	20%	19%	100%
MA*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MD	16%	16%	35%	6%	22%	5%	100%	14%	17%	23%	5%	16%	26%	100%
ME	15%	27%	22%	3%	14%	18%	100%	15%	26%	21%	5%	16%	18%	100%
MI	18%	21%	24%	3%	15%	19%	100%	16%	22%	25%	2%	14%	20%	100%
MN	18%	22%	24%	14%	11%	11%	100%	16%	20%	34%	1%	13%	16%	100%
MO	15%	23%	17%	2%	20%	22%	100%	15%	26%	18%	2%	15%	23%	100%
MS	16%	20%	22%	2%	19%	21%	100%	14%	22%	27%	2%	16%	19%	100%
MT	15%	29%	20%	5%	14%	17%	100%	16%	30%	20%	4%	13%	18%	100%
NC	15%	25%	23%	1%	16%	19%	100%	13%	25%	22%	1%	17%	22%	100%
ND	16%	20%	30%	2%	16%	17%	100%	16%	20%	35%	2%	14%	14%	100%
NE	15%	26%	18%	4%	12%	24%	100%	16%	26%	22%	2%	11%	22%	100%
NH	15%	22%	20%	4%	17%	23%	100%	13%	27%	22%	5%	15%	17%	100%
NJ	15%	20%	24%	4%	17%	20%	100%	14%	18%	24%	5%	16%	23%	100%
NM	15%	25%	17%	2%	14%	27%	100%	15%	28%	18%	3%	12%	23%	100%
NV	18%	17%	16%	9%	16%	23%	100%	16%	20%	20%	6%	13%	25%	100%
NY	16%	15%	20%	13%	22%	14%	100%	18%	16%	21%	10%	20%	15%	100%
OH	15%	24%	17%	2%	19%	22%	100%	17%	28%	18%	2%	15%	19%	100%
OK	18%	23%	15%	5%	19%	20%	100%	15%	23%	19%	6%	18%	19%	100%
OR	16%	22%	28%	5%	15%	13%	100%	16%	21%	27%	6%	12%	18%	100%
PA	17%	22%	17%	8%	17%	19%	100%	15%	22%	20%	7%	18%	18%	100%
RI	14%	20%	23%	2%	17%	24%	100%	15%	22%	23%	3%	16%	21%	100%
SC	16%	18%	16%	3%	28%	19%	100%	15%	25%	19%	3%	19%	20%	100%
SD	16%	26%	23%	2%	16%	17%	100%	17%	24%	25%	3%	16%	16%	100%
TN	17%	19%	21%	4%	19%	20%	100%	14%	19%	26%	2%	18%	21%	100%
TX	19%	18%	19%	4%	17%	23%	100%	17%	25%	19%	4%	15%	19%	100%
UT	20%	24%	19%	11%	17%	10%	100%	20%	22%	20%	11%	17%	11%	100%
VA	17%	21%	24%	3%	17%	19%	100%	15%	20%	24%	3%	17%	21%	100%
VT*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
WA	17%	19%	24%	5%	16%	19%	100%	16%	20%	25%	4%	14%	21%	100%
WI	14%	23%	23%	4%	13%	23%	100%	13%	23%	25%	5%	12%	22%	100%
WV	19%	31%	17%	2%	14%	17%	100%	17%	32%	20%	2%	14%	16%	100%
WY	19%	27%	21%	4%	11%	17%	100%	17%	25%	24%	3%	12%	19%	100%
Total	**18%**	**20%**	**21%**	**6%**	**17%**	**19%**	**100%**	**17%**	**20%**	**22%**	**7%**	**16%**	**19%**	**100%**

* Massachusetts and Vermont have merged the individual and small group markets and thus does not have individual market information available.

Appendix 2: Specialty Pharmacy Member Cost-Sharing by State, 2018

Note: "Frequency" reflects the historical proportion of members enrolled in a plan with a copay or coinsurance applied to specialty drugs. "Avg. Level" reflects the average value of the copay or coinsurance for those individuals.

	ACA INDIVIDUAL MARKET				ACA SMALL GROUP MARKET			
	SPECIALTY RX COPAY		SPECIALTY RX COINSURANCE		SPECIALTY RX COPAY		SPECIALTY RX COINSURANCE	
ST.	FREQUENCY	AVG. LEVEL	FREQUENCY	AVG. LEVEL	FREQUENCY	AVG. LEVEL	FREQUENCY	AVG. LEVEL
AK	0%	N/A	100%	40%	0%	N/A	99%	45%
AL	86%	$243	0%	27%	97%	$172	1%	20%
AR	84%	$224	13%	37%	93%	$120	2%	26%
AZ	0%	N/A	48%	50%	0%	N/A	88%	37%
CA	0%	N/A	97%	39%	0%	$60	98%	28%
CO	18%	$545	73%	41%	73%	$273	15%	27%
CT	0%	N/A	98%	32%	0%	N/A	97%	50%
DC	77%	$139	19%	27%	0%	$100	99%	50%
DE	0%	N/A	66%	28%	0%	N/A	13%	40%
FL	0%	N/A	70%	48%	91%	$281	9%	29%
GA	0%	N/A	57%	45%	34%	$198	63%	33%
HI	10%	$200	78%	34%	84%	$200	16%	50%
IA	7%	$250	91%	30%	59%	$151	20%	49%
ID	0%	N/A	85%	38%	0%	N/A	91%	31%
IL	1%	$176	92%	42%	42%	$83	52%	48%
IN	0%	N/A	64%	31%	46%	$244	46%	27%
KS	41%	$201	16%	30%	0%	N/A	100%	48%
KY	9%	$90	87%	39%	0%	N/A	100%	27%
LA	0%	N/A	97%	40%	0%	N/A	74%	10%
MA*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MD	44%	$101	35%	37%	1%	$100	99%	50%
ME	0%	N/A	98%	50%	2%	$500	98%	27%
MI	2%	$225	64%	41%	2%	$172	85%	22%
MN	1%	$250	65%	31%	0%	$220	46%	19%
MO	1%	$100	75%	43%	6%	$100	94%	33%
MS	13%	$100	27%	29%	96%	$100	4%	16%
MT	16%	$215	57%	48%	39%	$190	10%	41%
NC	0%	N/A	75%	26%	0%	N/A	0%	N/A
ND	0%	N/A	75%	29%	0%	N/A	96%	36%
NE	4%	$250	95%	30%	0%	N/A	79%	40%
NH	53%	$325	46%	40%	0%	N/A	87%	28%
NJ	0%	N/A	99%	50%	4%	$60	44%	48%
NM	9%	$500	88%	39%	20%	$150	78%	28%
NV	0%	N/A	76%	46%	69%	$325	29%	24%
NY	57%	$72	5%	100%	10%	$62	1%	47%
OH	0%	N/A	65%	38%	45%	$203	52%	34%
OK	0%	$160	99%	45%	96%	$162	3%	38%
OR	0%	N/A	75%	49%	15%	$294	80%	32%
PA	0%	N/A	93%	49%	24%	$95	74%	40%
RI	58%	$66	39%	50%	63%	$111	35%	49%
SC	0%	N/A	89%	32%	79%	$258	6%	38%
SD	3%	$150	80%	41%	48%	$153	33%	46%
TN	0%	N/A	93%	42%	64%	$155	29%	41%
TX	0%	N/A	78%	44%	72%	$150	8%	45%
UT	0%	N/A	84%	47%	0%	N/A	90%	28%
VA	1%	$150	95%	42%	0%	$100	95%	32%
VT*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
WA	0%	N/A	78%	46%	5%	$252	93%	30%
WI	1%	$433	77%	34%	2%	$134	78%	29%
WV	0%	N/A	100%	41%	0%	N/A	82%	40%
WY	0%	N/A	100%	31%	0%	N/A	0%	N/A
Total	**7%**	**$199**	**75%**	**41%**	**20%**	**$184**	**61%**	**32%**

* Massachusetts and Vermont have merged the individual and small group markets and thus does not have individual market information available.